

My COPD Action Plan

I will have my doctor fill this out with me.

My name: _____

Date: _____

My address: _____

Name of my doctor or clinic: _____

Phone number of my doctor or clinic: _____

Who to contact for me in case of an emergency (family member or friend to call):

(Name) _____

(Phone number) _____

Your Healthcare Plus phone number : 1-800-973-6792

To feel better and make breathing easier:

1. I should use inhaled breathing medicine



_____	for _____	puffs every _____	hours
(Name of inhaled medicine)		(number)	
_____	for _____	puffs every _____	hours
(Name of inhaled medicine)		(number)	
_____	for _____	puffs every _____	hours
(Name of inhaled medicine)		(number)	

2. If I smoke, I should quit by: _____ (date)

To stop smoking: _____

3. I should use oxygen _____ hours a day. Set oxygen at _____ liters/minute.

4. I should do breathing exercises for _____ minutes _____ times a day.

5. I should visit the doctor or clinic every _____

I should bring my inhaler(s) with me each time I visit the doctor or clinic: ☐ Yes ☐ No

6. I should get a flu shot every fall: ☐ Yes ☐ No

7. I should get _____ exercise for _____ minutes _____ times a day.

(type of exercise)

8. I should call the doctor or clinic right away if:

- | | |
|---|---|
| • Breathing gets harder: <input type="checkbox"/> Yes <input type="checkbox"/> No | • Sputum changes color (darker): <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Sputum gets thicker: <input type="checkbox"/> Yes <input type="checkbox"/> No | • Coughing gets worse: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Coughing up more sputum: <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have a fever (feel hot or sick): <input type="checkbox"/> Yes <input type="checkbox"/> No |



(OVER)

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iHFS ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

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COPD Action Plan

(continued from other side)

Other medicines:

Name of my medicine	How much I should take	How often I should take this medicine	This medicine is for

I have had a pneumonia (vaccination) shot: ☐ Yes ☐ No

I have had a breathing test (spirometry) done: ☐ Yes ☐ No

I have had a skin test for tuberculosis: ☐ Yes ☐ No

I have discussed "Advance Directives" with my family and doctor/clinic: ☐ Yes ☐ No



My blood pressure is:

Date									
Reading									

Weight/Food:

Is it okay for me to add salt to food or to eat salty foods like bacon, sausage, canned soup? ☐ Yes ☐ No

Is it okay to eat fatty meat, chicken skin, lard or butter, fried foods, fast foods? ☐ Yes ☐ No

Is it okay to eat snacks between meals like fruit, peanut butter and crackers, milk? ☐ Yes ☐ No

Should I lose weight? ☐ Yes ☐ No

Should I gain weight? ☐ Yes ☐ No

Other instructions:

I should get emergency help when:

It is hard to talk: ☐ Yes ☐ No

It is hard to walk: ☐ Yes ☐ No

My heart beat or pulse is very fast: ☐ Yes ☐ No

My lips or fingernails turn gray or blue: ☐ Yes ☐ No

My breathing medicine does not help for very long or it does not help at all: ☐ Yes ☐ No

My breathing is still fast and hard even after medicine: ☐ Yes ☐ No